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Commentary

Making Universal Health Care Effective in Argentina: A Blueprint for Reform

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Abstract—The reform of a health care system requires attention to specific components but also to the creation of an environment that supports change. Argentina has achieved nominal universal health coverage (UHC) but it still needs to work on achieving effective universal health coverage, especially with regard to quality and equity. *Nominal coverage* means that everyone has been enrolled and has the right to access, and *effective coverage* means that people have actually received prioritized health care services. In this article, we present our proposals to advance UHC in Argentina. The article includes an overview of Argentina's health system, then introduces the driving forces for reform, and finally analyzes four key issues where we provide our action plan to implement health reform for moving Argentina forward. Overall, our ultimate goal is to provide actual UHC and not aspirational UHC in Argentina by strengthening provincial health systems through enforcing public insurance schemes; utilizing an explicit priority-setting approach to make decisions on health coverage; reducing health disparities in coverage and outcomes, at least on prioritized health problems; and building a primary care–oriented health care system.

INTRODUCTION

Argentina is an upper-middle-income country with a population of 44 million, most of whom live in large cities.[1] Noncommunicable diseases account for more than 70% of the burden of disease, and cardiovascular disease represents about one third of chronic diseases deaths in Argentina, a country that has almost completed the demographic, epidemiological, and nutritional transitions. Yet most of the nation's health resources are still dedicated to communicable diseases and mother and child health conditions.[2] In many aspects, Argentina has a highly developed health system, particularly by low- and middle-income countries standards.

Keywords: Argentina, health care, health system, reform, universal health coverage

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Compared with other countries in the region, its health care system performs well on several key indicators. However, its outcomes lag behind the country's potential, given that it is one of the leaders in the region with respect to health care spending per capita and human development (see Table 1). In short, the major health care problems in Argentina today are related to both equity and efficiency, as in many other countries in Latin America.

Health system performance in Argentina has been affected by the country's economic performance. Toward the end of the 1990s, the Argentine economy plummeted, affecting living conditions and leading to a deep economic crisis at the end of 2001. During the first half of 2002, after four years of deep recession, the gross domestic product (GDP) decreased 15%. In the same period, Argentina's inflation rate reached 70% and more than 50% of the total population was living below the poverty line. Public spending fell dramatically, and borrowing abroad became impossible because the country defaulted on loans.[3–5] Over the last decade, Argentina's economy recovered, helped in part by the increase of the international price of commodities and a huge devaluation that took place in 2002. That boosted the economy again[6] but also doubled the percentage of people living under the poverty line, today amounting to nearly 30% of the population, which is related to structural factors and has been difficult to reduce.[7]

Many of Argentina's health care shortcomings arise from its pluralistic and fragmented system. In the decade of the 1990s, Argentina underwent a profound reform of its health care system, as happened throughout Latin America. Although some reform objectives were specific to each country, a common issue was the effort to establish a mechanism that ensured a more efficient allocation of scarce resources and guaranteed a wider provision of health care services on the basis of equity and population needs. During this period, Argentina adopted an ambitious range of reforms, strongly influenced by international bodies such as the World Bank, the Inter-American Development Bank, and the International Monetary Fund. These reforms were in line with those implemented in other middle-income or transitional countries, mainly focusing on decentralization and restructuring of social security systems.[8]

In the past decade, many countries around the globe have set universal health coverage (UHC) as an aspirational goal for national health reform. The dimensions of UHC as defined by the World Health Organization run along three axes: the population that is covered by pooled funds; the proportion of direct health costs covered by pooled funds; and the health services covered by those funds.[9] Reich and colleagues[10] defined four groups of countries that are at different points in moving toward UHC: group 1 countries, such as Bangladesh and Ethiopia, are still struggling to set UHC in the national policy agenda; group 2 countries, such as Indonesia, Peru, and Vietnam, have made progress toward UHC but still face substantial gaps in coverage; group 3 countries, such as Brazil, Thailand, and Turkey, have accomplished many UHC policy goals but still need to make these achievements sustainable over time; and group 4 countries, such as France and Japan, have already reached UHC but still need to adjust their national policies to meet the demographic and epidemiological challenges of aging, degenerative diseases, and technological innovation. Argentina belongs to group 3, having achieved many UHC goals, and the country already faces some of the challenges of the more developed and mature health care systems in group 4.

In this article, we develop our proposals to advance UHC in Argentina. The article includes an overview of Argentina's health system, then introduces the driving forces for changes, and finally analyzes four key issues where we provide our action plan to implement health reform for moving Argentina forward.

OVERVIEW OF ARGENTINA'S HEALTH SYSTEM

Argentina has a fragmented and segmented health system[11] divided into three large sectors—the public, social security, and private sectors—as found in many Latin American countries.

The public sector, funded by taxes, is decentralized to the provinces, giving the federal Ministry of Health (MoH) a rather narrow (but strategic) role in national health policy stewardship. Public health funds usually flow from national to provincial to local budgets with no strings attached, leaving the central MoH with little leverage to improve efficiency or accountability or even influence provincial health spending. As a result, the federal level accounts for only 20% of the public sector health expenditures, as discussed below.[12]

The Federal Health Council convenes the federal minister and the provincial ministers of health, serving as a venue for the exchange of ideas and for negotiations between the nation and the provinces but with limited authority to make policy decisions.

Except for a handful of high-tech tertiary national hospitals, all public hospitals and primary care centers belong to the provinces or municipalities. Because all inhabitants of Argentina are entitled to receive health care from public facilities, mostly on demand, the public sector acts as a reinsurance for the health insurance plans (both social security and private), thereby maintaining a flow of free care for the whole population, including the insured population.

Variable	Value
Demographics	
Population, total (2018)	44,494.502
Population aged 65 and above (% of total population)	10.9
Socioeconomic conditions	
Human Development Index (2015)	0.827
Total adult literacy rate (% >15 years old, 2015)	98.1
GNI per capita, PPP (current international dollars)	18,489.4
GNI per capita, PPP (current USD)	12,440.3
Health expenditures	
Per capita (USD)	1,390
Percentage of GDP (2015)	10.2
Public sources (% of total)	70
Private (% of total)	30
Out-of-pocket (as a % of private health expenditures)	68.9
Health insurance	
Percentage of population covered (Obra Social [including PAMI] or prepaid health plans)	63.9
Percentage of population covered only by the public health system	36.1
Access	
No. of hospital beds per 10,000 population in 2012	50
No. of physicians per 10,000 population in 2005	32.1
No. of nurses per 10,000 population in 2005	3.8
No. of pharmaceutical personnel per 10,000 in 2005	5.1
Life and death	
Life expectancy at birth (years) (men, women)	76.3 (72.6, 80.2)
Mortality rate, infant (per 1,000 live births)	9.7
Mortality rate, neonatal (per 1,000 live births)	6.3
Mortality rate, under-five (per 1,000 live births)	12.5
Maternal mortality ratio (per 10,000 live births)	3.4
Fertility and childbirth	
Fertiliy rate, total (births per woman)	2.3
Births attended by skilled health personnel in 2010 (%)	99.7
Preventive care	
Children 12–23 months of age receiving measles immunization (%)	90
Prevalence of chronic diseases and risk factors (%)	
Obesity in adults 18 years	20.8
Overweight in children <5 years of age	9.9
Hypertension in adults (>18 years of age)	34.1
Diabetes in adults (>18 years of age)	9.8
Smoking	25.1
New HIV infections among adults 15–49 years old (per 1,000 uninfected population)	0.23

[a]GNI = Gross National Income; PPP = Purchasing Power Parity.

Sources: Data are from the World Health Organization[21] and World Bank, supplemented by country data. Argentina. Instituto Nacional de Estadística y Censos[1,7]; Ministerio de Salud de la Nación[25] (Estadísticas vitales 2016; National Risk Factors Survey 2013).

TABLE 1. Selected Characteristics of the Health Care System and Health Outcomes in Argentina[a]

Approximately 16 million people (36%) in Argentina have no insurance and rely solely on the public health sector of each province or district.[13] In fact, all Argentinian citizens and residents, including foreign workers or tourists, can get medical care free of charge in the country. In addition, the public hospitals are sometimes used by insured individuals requiring more complex and expensive diagnostic or therapeutic procedures.[14] This creates an important unmeasured cross-subsidization from the public subsystem to the social security health funds, because most public health facilities lack the information systems to identify the beneficiaries of social security who receive care as well as the capacity needed to

bill for health services in hospital and primary care centers. One of the policies implemented in the health reforms that took place in the 1990s was to give some public hospitals greater financial and managerial autonomy, calling them self-managed public hospitals.

Most public primary health care programs and services are still focused on mother and child health rather than chronic noncommunicable diseases for adults, following the tradition of "selective" primary care strategies in Latin America where public primary health care services are provided to the poor and the uninsured and only to particular vulnerable groups.[15]

The social security sector is the dominant health subsector in Argentina and consists of many different sick funds. The Obras Sociales Nacionales (OSNs), mostly managed by trade unions, are generally composed of workers within the same labor activity and their core family members. They provide health coverage to 14 million people. In addition, there is one Obra Social that includes all public employers in each province, called Obra Social Provincial (OSP), which provides coverage to seven million people (one per each of the 24 provinces/districts). Finally, five million elderly, as well as some people with disabilities, are covered by a nationwide social health insurance fund for retired workers (Programa de Asistencia Médica Integral [PAMI]), broadly comparable to the Medicare in the United States. Overall, the social insurance sector provides health coverage to 60% of the population.[12]

This sector consists of approximately 300 different Obras Sociales in scope and size. Unlike most of the countries in Latin America, the Argentinian social health insurance entities were never merged into a unified or manageable number of large health insurance funds.[16,17] Currently, 70% of the 269 OSNs have less than 30,000 beneficiaries, and 80% have less than 100,000, which makes them very inefficient due to their high administrative costs; in addition, their risk pools are highly unstable to deal with high-cost events. The OSNs are primarily funded by a compulsory payroll contribution from employees who each contribute 3% of their salary and employers contribute 6%. Each fund covers the employee and their direct dependents with the option to extend coverage to other family members.

In the mid-1990s, there was a deep health reform that affected the social security system. The underpinning principles were inspired by the neoliberal paradigm of the Washington consensus: promoting competition, engaging with the private sector, reducing labor taxes, and implementing a basic package of services.[8] Before the reforms, each health fund had absolute coverage rights over the formal workers in each job, and employees were not allowed to choose among funds to receive medical care. As a result, there were important differences among the benefit health packages offered by different OSNs, depending on the average salary in their activity and the number of dependents for each worker in each sector, which in turn varied following a social gradient. In fact, there was a 16-fold difference in the average revenue per beneficiary among OSNs.[14] Many individuals or companies sought to supplement their coverage by contracting a private insurance plan, giving rise to multiple health coverages per individual.

After the reforms, formal employees were given the option of choosing their OSN and, therefore, OSNs started competing with each other to capture beneficiaries. Some of them subcontracted private insurance plans to provide supplementary or better-quality services to their beneficiaries. These contracts encouraged high-salary workers of some OSNs to migrate to other OSNs with arrangements with private insurance plans, producing a cream-skimming practice that eroded the solidarity not only between OSNs but also within OSNs. Currently, the number of beneficiaries who switched from one OSN to another fund is twice as high among those with a high salary, and the average contribution among workers who moved is 60% higher than the overall salary average contribution per employee.[18] On the other hand, affiliation has remained mandatory for formal workers and their dependents.

At present, revenues from contributions from wages of employers and employees are collected by the Federal Administration of Public Revenues, which in turn allocates approximately 80%–90% of the monies back to the OSN. To compensate for the differences that may result in potential health inequities due to the disparities in earnings for each of the OSNs, a redistribution fund (Fondo Solidario de Redistribución [FSR]), composed of 10%–20% of each payroll contribution, transfers money from the wealthier to the poorer OSNs. The health benefit plan (HBP) guaranteed to all formal workers is called the "Compulsory Medical Plan" or PMO. In addition, there is an ex-post risk sharing fund (Sistema Único de Reintegro [SUR]) to reimburse OSNs for most of the high-tech, high-cost diagnostic/therapeutic procedures, expensive drugs, and many of the newer and costly technologies.

The private insurance sector covers approximately six million people, where four million come from OSNs contracting private supplementary plans and two million are enrolled on an individual basis through direct and voluntary prepayments in approximately 200 private insurance or prepaid health plans.[12] In 2011, the congress passed a law to mandate the Superintendencia de Servicios de Salud to oblige all private health insurances to cover the PMO as a minimum HBP offered to their affiliates.

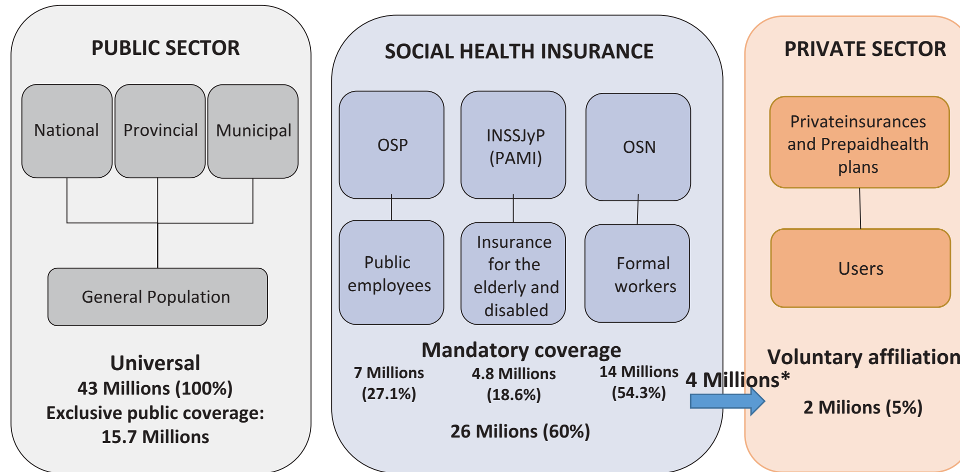

FIGURE 1. Structure of Health System Financing. Source: Adopted from Cetrangolo and Goldschmit.[12] *Many individuals companies sought to supplement their coverage by contracting a private insurance plan, giving rise to multiple health coverages per individual. Two million people have only private insurance and four million people have both social health insurance private insurance.

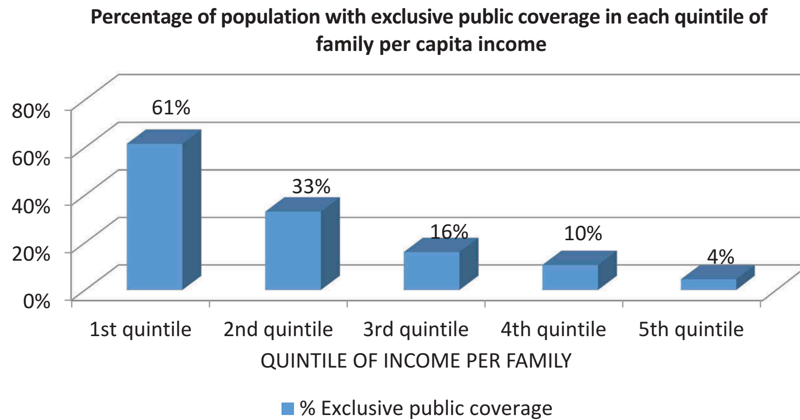

FIGURE 2. Income Distribution and Coverage. Source: MoH-Elaboration based on EPH second quarter 2017-INDEC.[7] http://www.indec.gob.ar/bases-de-datos.asp

Sources of health coverage can be seen in Figure 1. Regarding equity in health care insurance, there is a marked income gradient in insurance coverage, as seen in Figure 2, where more than 60% of the poorer 20% of the population has no insurance, compared to less than 10% in the wealthier 20%. Because most of the social health insurance funds are too small to provide services directly, they purchase health services from private clinics and hospitals, which in turn has created a large private provision sector representing about 50% of hospital beds and ambulatory facilities in the country,[19] taking care of most social security beneficiaries and private insurance affiliates.[14] It is calculated that up to 90% of the contributions collected by the OSNs go to private providers.[20]

In 2015, Argentina spent 10.2% of its gross domestic product in health care,[12] representing a per capita health expenditure of 1,390 USD, making it one of the leading spenders on health care in Latin America.[21] The Obras Sociales account for 40% of health expenditure. However, the private sector (private providers and private insurance) is also important and accounts for 30% of total health expenditure, almost two thirds of which comes from out-of-pocket payments from households and one third from prepaid payments to private insurance plans.[12] Importantly, private health spending in Argentina is in general equal to or lower than that in other similar Latin American countries: Uruguay 30%, Chile 39%, Brazil 57%.[21]

DRIVING FORCES FOR CHANGES

Although historically health care reform has not been a priority for Argentinian society, there are rising external and internal factors promoting reform that are concerning health financers, providers, and the public at large, and thus politicians are paying increasing attention. The bottom line is that Argentina spends more than 10% of its GDP in health without getting the results that would be expected according to that expenditure, compared to neighboring countries such as Chile and Uruguay.

Argentina´s health care structural flaws and shortcomings can be observed throughout all three major subsectors in different ways:

> In the public sector, problems arise through its federal organization and failed decentralization policies to subnational levels in the funding and provision of health services, implicit rationing based on an aspirational HBP but without an actual or explicit HBP offered to the population, lack of primary care orientation of most of public provincial systems, low institutional capacity and underdeveloped information systems in poor provinces, and wide inequality among districts in health care utilization and outcomes.

> In the social security sector, problems arise mainly due to the high number and small and uneconomic size of most Obras Sociales that include risk pools, weak management, unequal revenue based on average wages of different activities, poor income redistribution through a central solidarity fund (FSR), lack of explicit criteria to define and update the HBP (PMO) and the high-cost reimbursement fund (SUR), poor information systems and accountability, lack of transparency, and wide variability in benefits actually provided in Obras Sociales for white versus blue collar workers.

> In the private insurance sector, problems arise due to a rigid regulatory framework that obliges plans to accept all new technologies covered by the PMO or SUR but at the same time hinder premium setting. In effect, a special authorization from both the MoH and the Ministry of Commerce is required to increase premiums, which creates challenging problems in the context of Argentina's high inflation rate.

A BLUEPRINT FOR ARGENTINE HEALTH CARE REFORM

As the team responsible for health care in the Argentine government, we are now devising a roadmap to integrate health care in the nation and overcome the costly and ineffective health system. This reform confronts many challenges. In order to achieve *effective UHC*, meaning that people actually receive prioritized health care services, so that UHC goals are translated into outcome improvements on prioritized conditions, Argentina will need to address and correct some of the dysfunctional gears in the health system. In approaching this reform process, we have decided to focus on four key issues (see Table 2). After describing each strategic challenge, we provide, in italics, our proposed actions for reform. This is our blueprint for Argentina's health care reform and improved performance of the national health system.

Key Issue	Strategies
Establishing provincial public insurance schemes	Capitation payments will be transferred from the national level to the provinces to cover a share of the cost of health services included in a prioritized HBP for the eligible population National Health Fund for selected high-cost and low-incidence health conditions according to the priority HBP
Creating a public deliberative process for making hard decisions	Prioritize a package of benefits through an explicit deliberative process Creation of a federal agency of health technology assessment
Reducing disparities in effective coverage	Explicit clinical care pathways with indicators and quality targets
Building a primary care–oriented health care system	Strategy of family health teams Population empanelment in designed catchment areas, accomplishment of quality targets at PCC, and enforcement of adequate referral through local and regional integrated networks of health care

TABLE 2. Key Issues Faced by Argentinian Health Care System and Proposed Action for Reform

Establishing Provincial Public Insurance Schemes

Social health insurance is well established in Argentina, despite its flaws and limitations. As in other countries with social security systems, Argentina's Obras Sociales provide coverage to formal workers first because these groups are politically influential and, second, because they generate revenues to the state through the payment of taxes.[10] One major question is how to provide coverage for populations that currently lack health insurance. Public health services are devolved to the provinces and there is an OSP that gathers

the employees of the public administration within each province. One strategy to expand coverage is to facilitate from the federal level the creation of subsidized health insurance for the uninsured at the provincial level as a first step and then to integrate this population later within the OSP to form a larger provincial risk pool as a second step, with a contributive and a subsidized component. In this regard, integration also means to agree on a socially acceptable package of services and harmonized standards of care.

In this regard, Argentina's Nacer/Sumar program offers a good platform to launch this strategy. Programa SUMAR is a national program, sponsored by the World Bank, that has made a big leap in the public sector to advance our UHC strategy by (1) strengthening the insurance scheme in a traditionally supply-driven public health care sector, poorly responsive to people demands and social preferences, and (2) implementing a result-based financing approach through financial incentives to provinces, conditioned upon the accomplishment of explicit metrics based on agreed-upon goals between provinces and the federal level. Over the last 10 years, Programa SUMAR has enrolled more than 15 million people, almost all of whom have only public sector coverage. Although the health benefit package is limited and mostly focused on maternal and child health, it is the only national program that has implemented a form of public health insurance at the provincial level. Some evaluation studies show that Programa SUMAR has had large positive effects on birth outcomes, reducing low birth weight rates by 9%. Birth records from large maternity wards also show that the probability of in-hospital neonatal death was reduced by 22% for users of Plan Nacer clinics.[22]

This expansion of public health insurance has to be accomplished in a way that respects the fiscal responsibility of the provinces. All of the provinces are struggling to receive a larger share of federal co-participation of public monies, and, of course, co-participation of taxes to the provinces through fiscal transfers is necessary to fund hospitals, primary care centers, and providers. Currently, there are no strings attached to these money transfers from federal to provincial levels, and the provinces as a result take these funding flows for granted. To be specific, the transfers today do not include incentives to change fiscal behaviors in health issues or improve quality or productivity. The experience of the Programa SUMAR shows, on the other hand, how the activities of the public sector can be shaped through the introduction of an insurance scheme and pay for performance for both the provinces and providers.

This expansion of coverage to the uninsured poor will require strong political commitment to overcome interest group politics, particularly when it implies more fiscal pressure on the formal sector of the economy to subsidize the informal sector. An incremental approach to health coverage may be more feasible and in the long run can also lead to the creation of different risk pools, funded through different sources, targeted to different population groups and with different coverage of health services.[23] Once these different risk pools are established, it may be more difficult to integrate or harmonize them, because this integration involves redistribution of resources across different interest groups in terms of influence and power. Some experiences in Argentina creating such insurance schemes at the beginning of this century failed, in part due to poor design but mostly due to the widespread recession that hindered changes that could support redistribution of benefits at that time.

Our Proposal

For the first stage of provincial health reform, we will focus on the implementation of public insurance schemes for the uninsured, building on the existing platform of Programa SUMAR. Capitation payments will be transferred from the national level to the provinces to cover a share of the cost of health services included in a prioritized health benefit package for the eligible population (see below). These payments would vary among provinces depending on the level of poverty and other key factors such as equity in health outcomes, access to health services, and institutional capacity for health service delivery. In addition, these payments may be adjusted based on the level of achievement of selected health indicators and the level of effective coverage. Reimbursement mechanisms would likely include a mix of capitation for the population in the public health care facility catchment area, fee-for-service, and pay-for-performance. Providers would have autonomy in the use of these funds (subject to some guidelines/procedures). In addition, a National Health Fund will be created to support coverage for selected high-cost and low-incidence health conditions according to the priority HBP by financing capitation payments from the MoH to a national risk pool, which should be used to pay for health services related to selected catastrophic diseases for the eligible population. This proposed action will significantly reduce the number of people who do not have insurance coverage.

Creating a Public Deliberative Process for Making Hard Decisions

One of the most difficult problems in health care is addressing the gap between what is medically possible and what is financially feasible and deciding on resource allocation. The decision is not about whether to prioritize but how best to accomplish this process.[24] A health benefit package can be a

good tool for rationing by way of explicit priority setting. However, it should be noted that to reap the benefits promised by the adoption of an HPB, other conditions must fall into place, such as consistency between an HBP's cost and its budget impact and the availability of human, technological, and physical resources, among others. In Argentina, the concept behind the state's obligation to its citizens to guarantee universal and equitable access to health care is enshrined in its constitution and laws. However, in practice, inadequate public resources for health care have resulted in waiting lists and hurdles to get services at the point of care, which can be considered a form of implicit rationing. Argentina needs to move from an aspirational but unattainable promise to an explicit, actual, achievable, and affordable list of services to which all population groups can have access. We propose to address this challenge.

In 1996, while engaged in the health reform process, Argentina started to consider more explicit criteria for health priority setting. At this time, our country defined an HBP to be covered as an acceptable minimum by the social security system. Under the concept of relative equity, an HBP, such as the Argentine PMO, could serve as that socially acceptable minimum, which also may vary according to the demands of the society.

Our Proposal

Our aim is move toward the expansion of effective universal health care coverage for all age groups, setting up a benefit package driven by an explicit deliberative process between the national level and the provinces based on the best scientific evidence of clinical and cost-effectiveness. This process will also incorporate other dimensions such as feasibility, budget impact, opportunity, and social preferences. The package will be based on the public sector and leverage the successful experience and results of Programa SUMAR and should converge gradually with the PMO of social security through the explicit coverage of interventions mapped with the prioritized health problem agreed on by all sectors (see next section). In this regard, the creation of a federal agency of health technology assessment will help set objective, transparent, and explicit criteria to define the HBP across the different health sectors. This public deliberative process will allow us to reduce the inequities that currently exist in the health benefit packages available to different populations in Argentina.

Reducing Disparities in Effective Coverage

Argentina's health system confronts a fragmentation of resource pools and lack of redistributive mechanisms; these two factors create structural problems of disparities. Yet there are few politically feasible ways at present to pool funds in both the public and social security subsystems or to establish redistributive mechanisms between the two. Within the public subsystem, the available financing per person varies widely across provinces, and there is no explicit redistribution fund to reduce the interprovincial disparities in health spending. Moreover, because the federal MoH has limited stewardship over the provincial ministries of health to enforce quality of health services, implementation is challenging for clinical guidelines and procedures, financial incentives, and information standards and systems. In fact, there is a sixfold difference in per capita spending between higher and lowest provinces.[25] These differences in spending are reflected in huge health disparities by region or type of health coverage. For example, the infant mortality rate has a national average of 9.7 per 1,000 and a twofold difference between poor and rich provinces and the maternal mortality rate has a national average of 3.4 per 10.000 and an eightfold difference between poor and rich provinces[26]; there is a longer time to reperfusion treatment in acute myocardial infarction, a strong predictor of mortality, between rich and poor districts and between affluent and poor Obras Sociales[27,28]; there is an eightfold regional variation in cervical cancer mortality, which is strongly associated with poverty; and a threefold regional variation in colorectal cancer mortality. These differences are explained by regional variations in screening and time to diagnosis and treatment.[29–33] Moreover, there are huge variations by region in health coverage for cardiovascular risk factors and screening practices for cancer prevention.

In order to improve public service quality, Chile initiated in 2004 a reform, called Plan AUGE, by selecting health problems for which several guarantees were made for patients to receive care in accordance with clinical guidelines, with appropriate times for diagnosis, treatment, and follow-up. AUGE, which now has a priority list of 56 health problems, was successful in improving quality and access of some services and reducing mortality rates, especially among lower-income Chileans.[34]

Our Proposal

We propose to adopt a strategy, inspired by the Chilean model, to seek consensus on the conditions and health problems that should be formally addressed through a formal priority-setting process that includes all of the players involved in the public, social security and private systems. Once which priority health problem are to be included is agreed on, explicit clinical care pathways with indicators and quality targets will be set in order to be met by all sectors in the health system. In this way, all parties will be committed

to start closing the gaps in health outcomes on key conditions. This proposal will significantly reduce disparities that exist for key health indicators.

Building a Primary Care–Oriented Health Care System

Argentina's health care system, due in part to its pluralistic and fragmented funding, organization, and delivery of health services, has a hospital-centered model poorly oriented to primary care. Almost all parts of the health system suffer from a heavy bias toward expensive specialist curative services through high-tech interventions, overlooking the central role of primary care in the whole system and restricting this strategy to vertical programs aimed only at the vulnerable populations. The health professional workforce mix shows this tendency, with almost two to three specialists per primary care physician and almost ten doctors for every qualified nurse.[35] A primary health care–based health system is composed of a core set of functional and structural elements that promote universal coverage and access to services that are equitable and acceptable to the population. It provides comprehensive, integrated, and appropriate care over time; emphasizes prevention and promotion; and assures first contact care. Families and communities are its targets for planning and action.[15]

Strong evidence has been collected on the effects of primary health care on health quality and outcomes in studies related to the supply of primary care physicians (PCPs), identification of a PCP as a regular source of care, and linking of quality primary care services with health status. These studies, mostly undertaken in the United States and Organization for Economic Cooperation countries over the last two decades, show that health is better in areas with more PCPs; that people who receive care from PCPs are healthier; and that the characteristics of primary care services in terms of first contact, continuity, comprehensiveness, and coordination are associated with better health status and lower mortality and morbidity.

Recently, many of these effects have been found in Latin American countries such as Cuba, Costa Rica, and Brazil.[36] Brazil is a good example of innovation in access and coverage implemented through the Programa de Saúde da Família (PSF). PSF provides primary care for defined populations by deploying core teams that include a family physician, a nurse, a nurse assistant, and four to six full-time community health workers. Family health teams are organized geographically, covering populations of up to 1,000 households each, with no overlap or gap between catchment areas. Each team member has defined roles and responsibilities.[37] The scaling-up of teams has been impressive: from about 2,000 teams including 60,000 community health agents providing services to seven million people (4% of the Brazilian population) in 1998 to 52,385 teams incorporating more than 346,394 community health agents, plus 5,000 oral health teams, together serving 193 million people (93% of the population) in 2017.[38] Numerous studies have shown that Brazil's PSF expansion has resulted in improvements in children's health, including large reductions in infant mortality from diarrhea and respiratory infections, and reductions in cardiovascular mortality and lower hospitalization rates among adults.[39]

Our Proposal

We propose to gradually expand georeferenced health coverage in primary care centers' (PCCs) catchment areas, starting first in small pilot areas in each district to later scaling up to larger areas of the same province or municipality. This process will be accompanied by the nomination of the population served in each catchment area (with a focus on the uninsured), assigning this defined population through a process of empanelment, to core family health teams (a family or general doctor, a nurse and two to three community health workers for approximately 1,000 households or 3,500 people). These core family health teams will be complemented by primary care teams composed of other medical practitioners who will interact with teams covering more primary care centers and larger populations. The process will be leveraged through specific financial and nonfinancial incentives (training of human resources, equipment, infrastructure, and supplies) for population empanelment in designed catchment areas, accomplishment of quality targets at PCCs, and enforcement of adequate referral through local and regional integrated networks of health care. This proposal will significantly improve the coverage and quality of primary care services available to vulnerable populations in Argentina.

MEASURING AND MONITORING IMPLEMENTATION

The instrumental components of the health reforms proposed above (public insurance schemes at the provincial level, explicit benefit schemes, prioritization of health problems targeted to reduce health disparities, and building core family health teams) are only the gears to drive changes that will translate into health outcome improvements in Argentina. These improvements, in turn, should be equitably distributed across different socioeconomic strata, country regions, and types of health coverage. Of course, to track whether these changes are achieved requires a health information system embedded in a national interoperability plan. This plan will provide measurable standards at the national level with the

aim of ensuring that the information generated by the different national and provincial health information systems, which includes the gradual implementation of electronic clinical records in the health facilities of the public and the social security sector, can be harmonized and used for surveillance, monitoring, and evaluation of interventions and policies and clinical decision making at the point of care.

As is well known, UHC is a strategy aimed at providing health services (prevention, promotion, treatment, rehabilitation, and palliative) for all people who need them, without undue financial hardship.[9] UHC consists of three interrelated components: (1) the full spectrum of quality health services according to need; (2) financial protection from direct payment for health services when consumed; and (3) coverage for the entire population. We are developing a system of UHC monitoring in Argentina that will ensure that progress toward UHC reflects the country's unique epidemiological and demographic profile, population demands, national and subnational health systems, and level of economic development.

The guiding principles used in Argentina's national monitoring of UHC[39] will include two related UHC dimensions: essential health services coverage and financial protection coverage for the population. Their measures will encompass the full population across the life cycle, including all ages and gender, and will capture all levels of the health system regarding effectiveness, equity, and quality. For instance, we will measure the effects and distribution of effects of policies and interventions to prevent and control childhood obesity or tobacco smoking, which are delivered society-wide. We will also measure rates and distribution of health service coverage for interventions targeted to reducing unintended pregnancies among adolescents or emergency obstetric care to reduce maternal mortality, which are targeted to particular age–gender groups or clinical interventions for control of hypertension, diabetes, or clinical CVD and screening for cervical, breast, or colorectal cancer prevention, which are targeted to adults. Other indicators, focused on vulnerable groups, will measure vertical transmission of HIV or Chagas disease, a highly prevalent vectoral disease in the north of the country, or reduction of the prevalence of hepatitis C, which is widespread among middle-age adults. Similarly, financial protection indicators to track the level of financial hardship when using health services will be measured, such as incidence of catastrophic health expenditures and incidence of impoverishment due to out-of-pocket health payments, through different household surveys.

CONCLUSIONS

The reform of a health care system requires a focus not only on its specific components but also on the creation of an environment that supports innovation conducive to change. Health system strengthening is a process that involves complex systems and therefore requires a vision and long-term strategies to accomplish the ultimate goals. Although Argentina has achieved nominal universal health coverage, the country still needs to work on achieving effective universal health coverage, especially with regard to quality and equity. In this regard, our ultimate goal is to provide *actual and not aspirational UHC* by strengthening provincial health systems through enforcing public insurance schemes, utilizing an explicit priority setting approach to make decisions on health coverage; reducing health disparities in coverage and outcome, at least on prioritized health problems; and building a primary care–oriented health care system.

The current administration of President Macri in Argentina has shown a remarkable open-minded attitude with respect to "change things that are not doing well rather than do better what it has been doing wrong." The national UHC strategy was officially announced by the Macri government through a national decree (908/2016). Health care reform in Argentina represents a big challenge, but it also represents a huge and timely opportunity for a lasting change. In the end, we can say, paraphrasing the title of Primo Levi's famous novel, "If not now, when?"

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflict of interest was reported by the authors.

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